

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13041

13029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour Min.
JENNIE AMANDA ANDERSON				SEPT. 15 1968	07 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
FEMALE	WHITE	2-11-94		74 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH		
MARYLAND	UNITED STATES	KENT CO.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
CHESTER TOWN	KENT Co Queen Anne's			House WORK	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY, OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
MARYLAND	Queen Anne	Sudlersville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
John	Thomas	Anderson		Georgia	Burgess
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
No	216-54-8985	Hospital Records	Chester Town, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) <u>Years.</u> 4109					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Obstruction of coronary arteries causing intestinal obstruction</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> , 19 <u>68</u> , to <u>Sept 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A.C. Dick</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9-15-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>	22e. ADDRESS <u>Chester Town, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/18/68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Sudlersville Cemetery</u>	23d. LOCATION (City or Town) <u>Sudlersville</u>	(County) <u>Q.A.</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Edward Fellows & Son,</u>	ADDRESS <u>Millington, Md. 21651</u>	25a. REC'D BY REGISTRAR DATE <u>SEP 20 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13030

13042

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have a funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Rosie	Middle Mae	Last Blake	2a. DATE OF DEATH Month September	Day 27, 1968	Year 1968	2b. HOUR 1:20 A.M.				
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH May 6, 1934			6. AGE (in years last birthday) 34	YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.						
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #2							
14. FATHER'S NAME First Edward	Middle Thomas	15. MOTHER'S MAIDEN NAME First M A R Y	Middle Unk.	Last Unk.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. YES	17. INFORMANT Hospital Records, M	Address Chestertown, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174 X											
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMATOSIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) CARCINOMA OF BREAST											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170 X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
MEDICAL CERTIFICATION					YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 25, 1968 , to Sept. 27, 1968 , that (I) (we) last saw the deceased alive on Sept. 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gulbrandsen MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-27-68					
22d. PHYSICIAN'S NAME (Type) O. S. Gulbrandsen, M.D.		22e. ADDRESS Chestertown, Maryland 21620									
23a. BURIAL, CREMATION, (Specify) Burial		23b. DATE 9/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Sandy Bottom Cem.			23d. LOCATION (City or Town) R.F.D. Chestertown		(County) Kent		(State) Md.	
24. FUNERAL DIRECTOR Bennett Wile		ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			
					DATE OCT 3 1968						

10000

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 & 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four PMJ. Page 5 may be retained for your files.

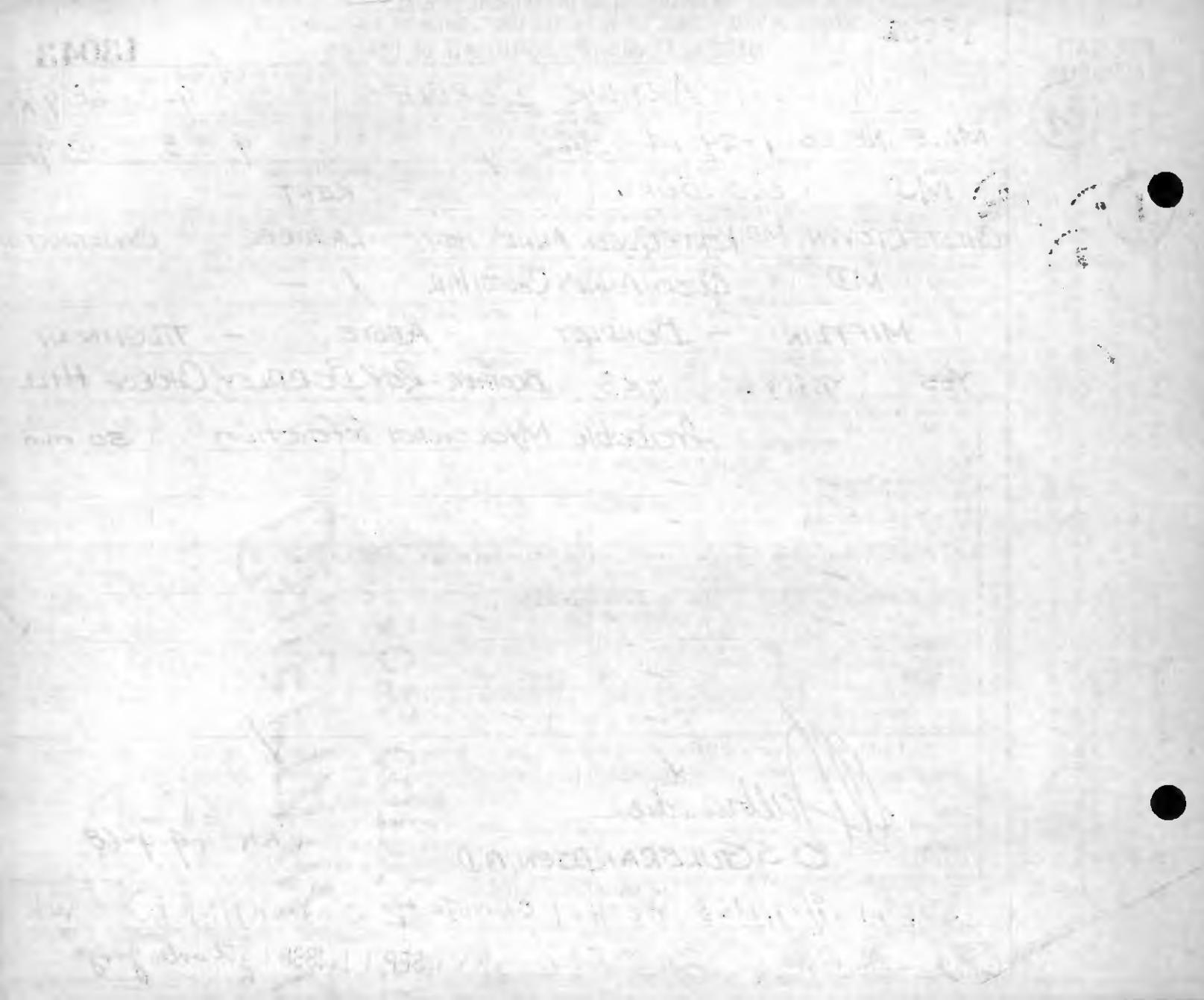
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13031 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13043

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN BY ESTI- MATED	Month	Day	Year	2b. HOUR 9:25 AM
		WILLIAM ARTHUR BORDLEY			<input checked="" type="checkbox"/>	9-8-68			
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years less than 1 year) 34 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN		2d. HOUR 9:30 AM
MALE	NEGRO	1-29-14							
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
MD.	U.S. BORN			KENT					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give exact address)			12a. USUAL OCCUPATION (Kind of work done during most recent week before if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CHESTERTOWN, MD	KENT QUEEN ANNE'S Hosp			LABORER			CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
MD	QUEEN ANNE'S CHURCH HALL YES	<input type="checkbox"/> NO <input checked="" type="checkbox"/>	—						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
I MIFFLIN			- BORDLEY	ABIE			- TILGHMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
YES	W 12	YES	BROTHER - ROY BORDLEY, CHURCH HILL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 Probable Myocardial Infarction								30 min	
DUE TO, OR AS A CONSEQUENCE OF (b) —									
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (c) —									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						2d. AUTOPSY?	
19c. MEDICAL CERTIFICATION								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I am in charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Actg							
		22b. DATE SIGNED 9-9-68							
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur. & P.		23b. DATE 9/14/1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) CHURCH HILL		(County) Q.A.	(State) MD	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR Date SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13044

1. DECEASED NAME (Type or print)	First Alverta	Middle Lee	Last Bostic	2a. DATE OF DEATH Month 9	Day 9	Year 1968	2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10-3-04			6. AGE (in years last birthday) 63	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent			Md.
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Queen Anne	13c. CITY OR TOWN Sudlersville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER none			
14. FATHER'S NAME Walter	First Lee	Middle Dukes.	15. MOTHER'S MAIDEN NAME Charlotte	Middle Loretta	Lost Deems		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 197-11-0233	17. INFORMANT Hospital Records	Address Chestertown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 174X <u>4 MONTHS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA OF BREAST</u> (c) <u>3 YEARS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 170X							
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> , 19 <u>68</u> , to <u>9-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> - 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>DR. Oteiza MD</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>9-9-68</u>			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Chestertown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Sept. 11	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SUDLERSVILLE	23d. LOCATION (City or Town) (County) (State) SUDLERSVILLE MD.				
24. FUNERAL DIRECTOR Edgar L. Lane - Church Hill, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 16 1968	25b. REGISTRAR'S SIGNATURE <u>Charles J. Lane</u>				

13045

exact

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

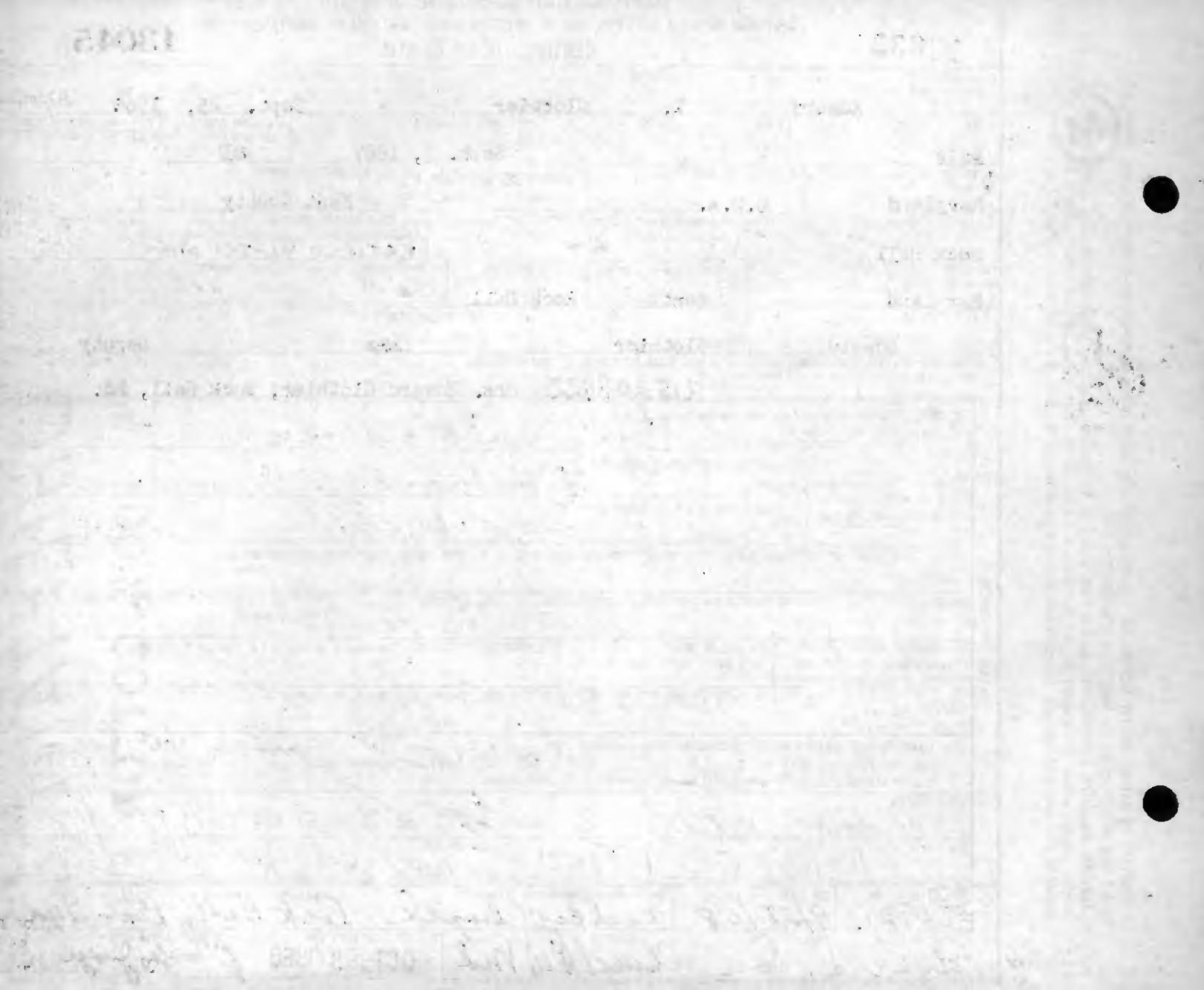
CERTIFICATE OF DEATH

13033

13045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 5:30 P.M.		
Edward				E.	Clothier	Sept. 25, 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		W		Sept. 7, 1887		81 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Kent County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rock Hall						Retired WATERMAN		x		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland		Kent		Rock Hall			x			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
		Edward		Clothier			Emma		Deputy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
Yes, no, or unknown)		218-208422		Mrs. Edward Clothier, Rock Hall, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Hypertension</u> last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Occlusion</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> , 1968, to <u>Sept. 25</u> , 1968, that (I) (we) lost sow the deceased alive on <u>Sept. 1</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert C. Ulrich</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Sept 28/68</u>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		<u>Rock Hall Md</u>						
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)	
BURIAL		9/28/68		Wesley Chapel		Rock Hall Kent Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
		<u>Edgar L. Sene Churchill, Md</u>		DAT OCT 3 1968		<u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

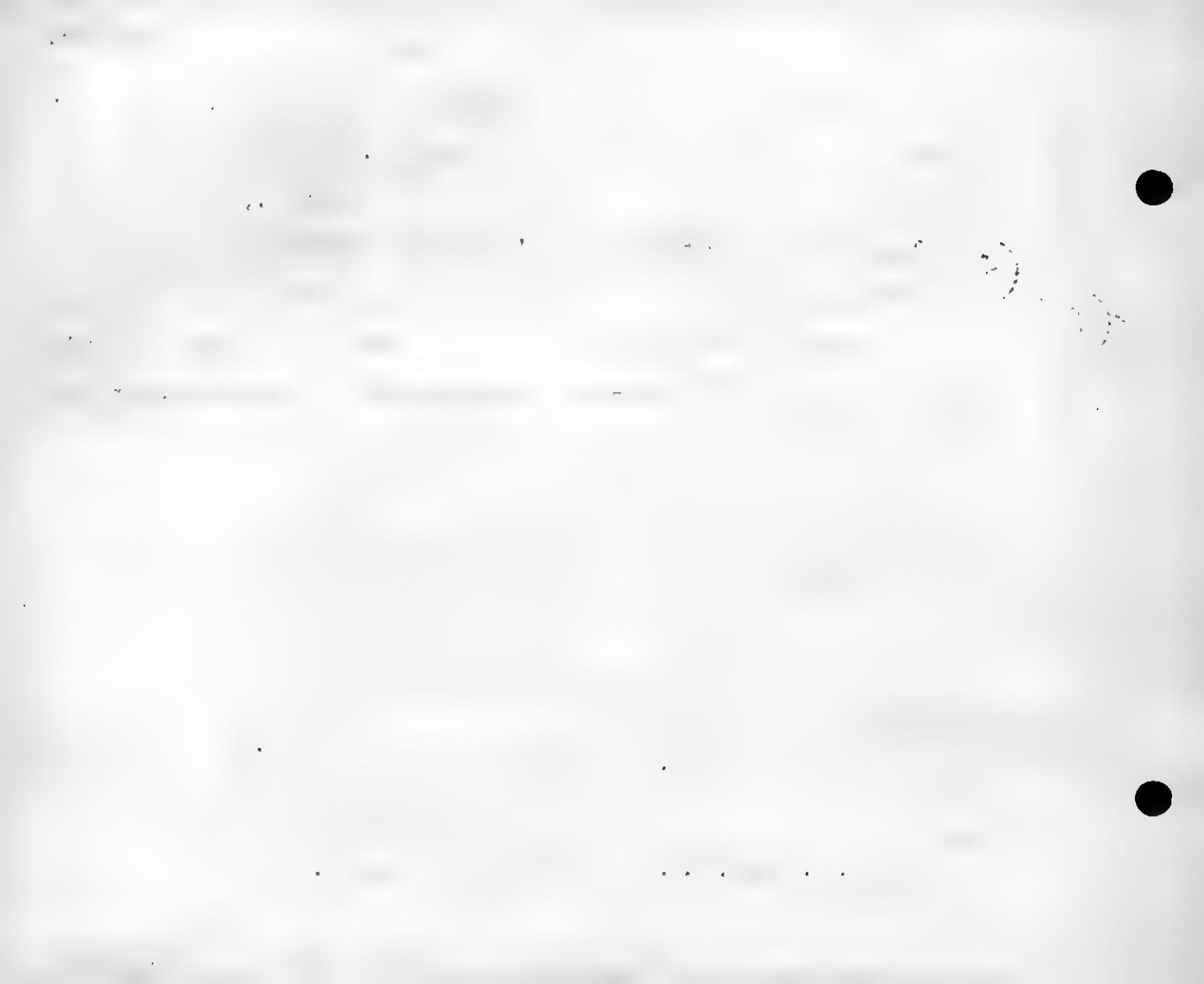
CERTIFICATE OF DEATH

13046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Anna	Middle Mae	Last Coleman	2a. DATE OF DEATH Month September Day 7, 1968 Year 9:15AM	2b. HOUR
3. SEX Female	4. RACE White	S. DATE OF BIRTH February 6, 1903	6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.,	Md.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Ulysses	Middle Grant	Last Col eman	15. MOTHER'S MAIDEN NAME First Annie	Middle Jane	Last Grukey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-10-2021	17. INFORMANT Hospital Records	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from May 29 , 19 68 , to Sept. 7 , 19 68 , that (I) (we) last saw the deceased alive on Sept. 7 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d.d.) (d.d.not) view the body after death.					
22b. SIGNATURE <i>A. T. Keefe</i>		DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9. 7.68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS A. T. Keefe, M.D.		22f. ADDRESS Chestertown, Maryland		
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 9	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel	23d. LOCATION (City or Town) Rock Hall	(County) Kent MD	(State)
24. FUNERAL DIRECTOR <i>Edgar L. Keefe</i>	ADDRESS <i>Laura Church Hill Md.</i>	25a. REC'D BY REGISTRAR DA SEP 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Report 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a copy of the death certificate. Page 3 may be retained for your files.

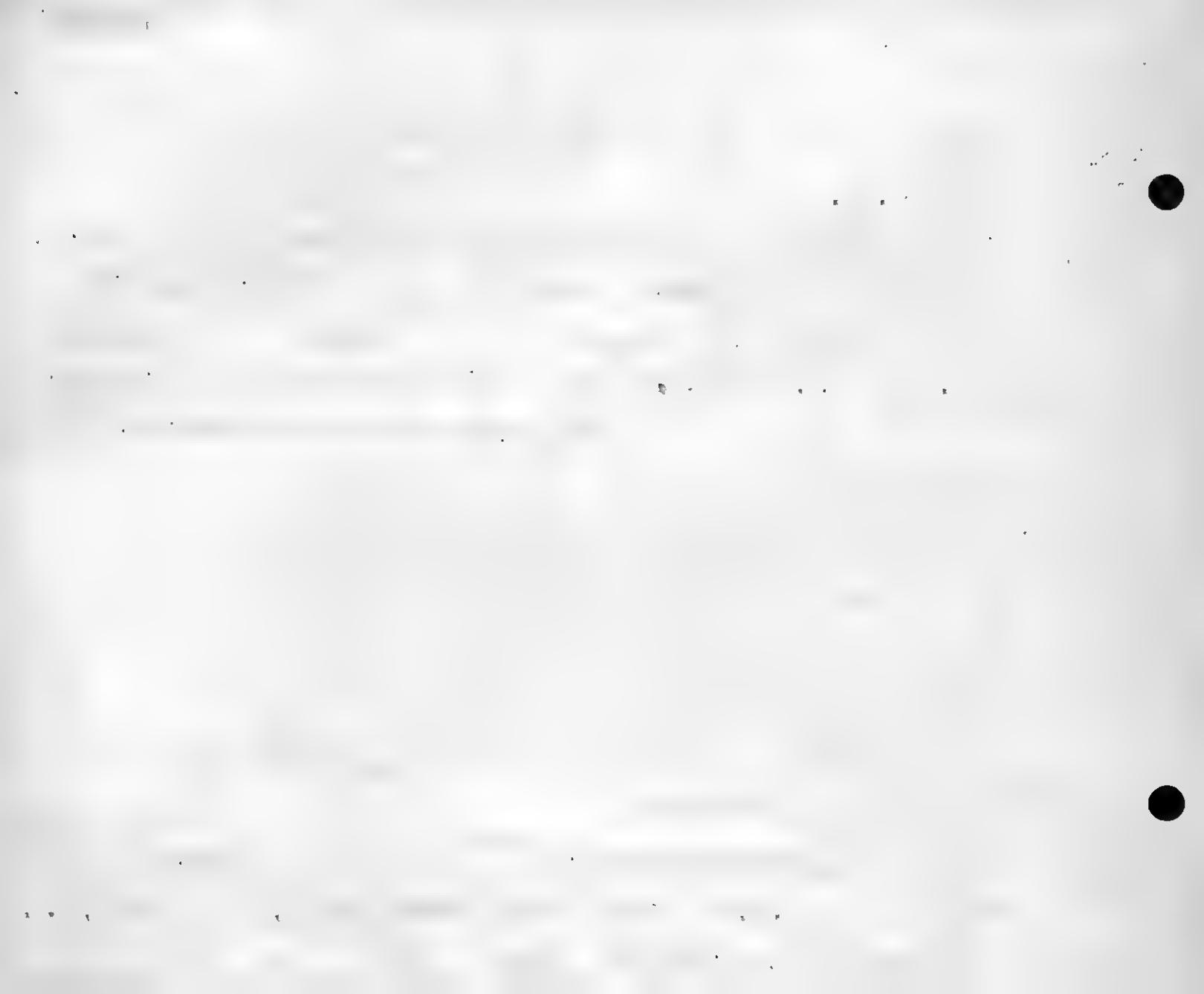
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13047

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b HOUR				
JOHN MATHEW FENNEN						OF EST 9-5-68		2:30 P.M.				
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 7-23-21		6 AGE (In years In months) 47 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Phila. Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH KENT		2c. DATE PRONOUNCED DEAD Month 9 Day 5 Year 68				
10. CITY OR TOWN OF DEATH NEAR GALENA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOAT YARD-GREENECK COopersmith			12a. USUAL OCCUPATION (Kind of work done during most working day, even if retired) NAVY YARD			2d. KIND OF BUSINESS OR INDUSTRY NAVY YARD			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE No. J.			13c. CITY OR TOWN LINDENWALD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 223 W. LINDEN AVE				
14. FATHER'S NAME First William Middle Fennen Last			15. MOTHER'S MAIDEN NAME First Marie Middle Scheifler Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.			16b. SOCIAL SECURITY NO W.W. 11 209-09-7215			17. INFORMANT GUSTAVE CORNEY-MTEPHRAIN, N.J.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PRESUMABLY MYOCARDIAL INFARCTION - INSTANT									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7109			DUE TO, OR AS A CONSEQUENCE OF (b) _____									
			DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>O. S. Gulbrandsen</i>		EXAMINER'S NAME (Type) <i>O. S. Gulbrandsen, MD</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTG DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b. DATE SIGNED 9-5-68		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Sept. 10, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery			23d. LOCATION (City or Town) Berlin, (County) Camden, N.J. (State)					
24. FUNERAL DIRECTOR <i>Edward Fellow Wellington Jr.</i>		ADDRESS			25a. REC'D BY REGISTRAR DATE SEP 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13036

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13048

1 DECEASED-NAME (Type or Print)		First Mary	Middle Virginia	Last Finley	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 9	Day 15	Year 1968	2b HOUR 4:49		
3. SEX Female	4 RACE White	5 DATE OF BIRTH 2-17-1886	6. AGE (In years last birthday) 82 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2c DATE PRONOUNCED DEAD Month 9	Day 15	Year 1968	2d HOUR 4:55M
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH Kent					
10. CITY OR TOWN OF DEATH Chestertown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY Md	
13a US JA. RESIDENCE (Where deceased lived, if institut admission) STATE Maryland		13b. COUNTY Kent		13c CITY OR TOWN Kent & Queen Church Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER none			
14. FATHER'S NAME William		Middle Name Middlemores	Co. Co.	15. MOTHER'S MAIDEN NAME Addison Bradley	First Susan	Middle Jane	Last Massey				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 216-14-2559		17. INFORMANT Hospital Records - Emergency Room Report		ADDRESS Chestertown, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several Year			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF 41dx9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a DATE OF OPERATION 4221		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH WHILE AT WORK		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Autopsy							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Church Hill		21f LOCATION Street or R.F.D. No Church Hill		City or Town Chestertown		County Md		State	
22a. I certify that I took charge of the remains described above, held on Sept. 17 Autopsy <input type="checkbox"/> Inspector <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Robert W. Farr</i>		MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Sept. 15, 1968			
EXAMINER'S NAME (Type) Robert W. Farr Chestertown, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Sept. 17		23c NAME OF CEMETERY OR CREMATORIUM Church Hill		23d LOCATION (City or Town) Church Hill, Maryland		(County) Md		(State)	
24. FUNERAL DIRECTOR Edgar L. Lane		ADDRESS Church Hill, Maryland		25a REC'D BY REGISTRAR SEP 19 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13037

13049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, **detach**, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **Keep** pages 1 and 2 **in the funeral** director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Arthur	Middle Vernon	Last Fowler	2a. DATE OF DEATH Month Sept.	Day 8	Year 1968	2b. HOUR 7:29		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 27, 1908		6. AGE (In years last birthday) 60		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent				
10. CITY OR TOWN OF DEATH Worton RFD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ---		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineering Tech.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Kent		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ---				
14. FATHER'S NAME First Adam		Middle C.	Last Fowler	15. MOTHER'S MAIDEN NAME First Hester		Middle Olivia	Last Carroll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-01-4199		17. INFORMANT Elisabeth H. Fowler		Address Worton, Md. RFD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c) A.I.S.C.V.D.		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease		SEVERAL YEARS				
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 6-23 , 19 68 , to 9-8- , 19 68 , that <input type="checkbox"/> (we) last saw the deceased alive on 19 , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE Jorge A. Oteiza		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-9-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS JORGE A. OTEIZA MD CHESTERTOWN - MARYLAND.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-11-68		23c. NAME OF CEMETERY OR CREMATORIAL Galena Cemetery		23d. LOCATION (City or Town) (County) (State) Galena Kent Md.				
24. FUNERAL DIRECTOR		ADDRESS Victor N. Kennedy Still Pond, Md.		25a. REC'D BY REGISTRAR DATE SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

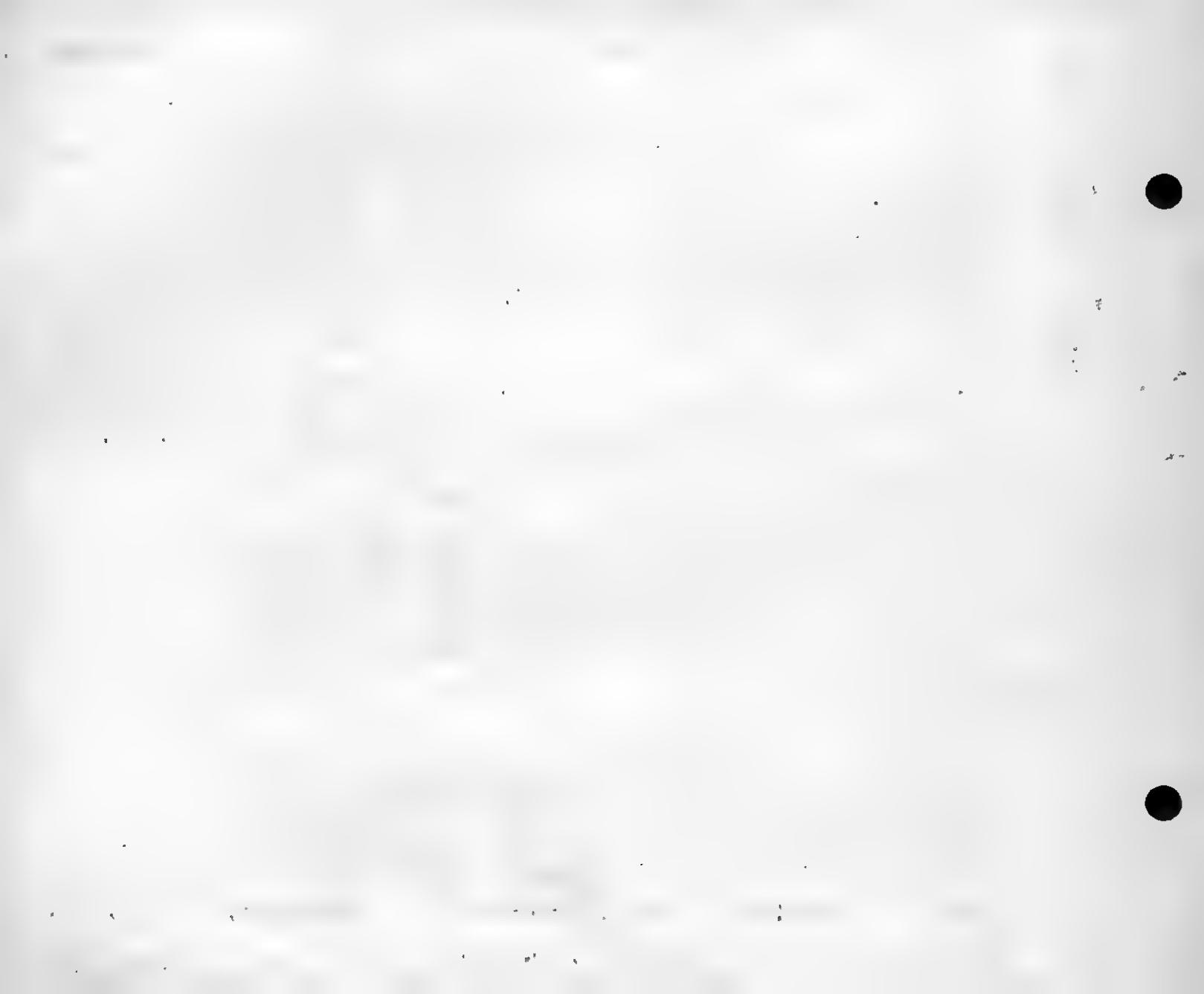
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13038

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13050

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR										
<i>EVA</i>			<i>Gardiner</i>			<input checked="" type="checkbox"/>	Sept	22	1968	6 AM										
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	7	77	YRS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month Day Year									
7	W	<i>Jan 3, 1887</i>	77								Sept 22 1968									
7d. BIRTHPLACE (State or foreign country)	7e. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH																
<i>Del.</i>	<i>U.S.A.</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>Kent County</i>																
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY													
<i>Rurals-</i> <i>Kennedyville, Md.</i>				<i>Housewife</i>			<i>home</i>													
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY (AM 15?)	13e. STREET AND NUMBER																
<i>Md</i>	<i>Kent</i>	<i>Millington</i>	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO																
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last													
	<i>William</i>	<i>Ellingsworth</i>			<i>Hettie</i>	<i>Shorts</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
No.		<i>Mrs Wm Schreiter</i>			<i>Kennedyville, Md.</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cerebrovascular Cardiovascular Disease several years</i>																				
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>																				
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i></i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?														
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State								
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>Robert W. Farr</i>											CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>											M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											23b. DATE 9/25/68			23c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery			23d. LOCATION (City or Town) Millington,		(County) Kent,	(State) Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,											ADDRESS Millington, Md. 21651			25a. REC'D BY REG STRAR DATE SEP 25 1968		25b. REG STRAR'S SIGNATURE <i>Charles J. Geiger</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trousser permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 3:30 P.M.
Wm Francis Goodman						Sept. 1968	
3. SEX		4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M		W	3/5/02				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
Baltimore Md.		U.S.A.				Baltimore	
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) East Rock Island Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY	
Md							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md		Baltimore		Rock Hall		YES <input type="checkbox"/>	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S Maiden Name	First	Middle
Wm		W.	Goodman		Mary Anna Pearce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 211-30-9943		17. INFORMANT Mrs. Mary Freeman		Address Rock Hall Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
BETWEEN ONSET AND DEATH 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chest infection</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William J. Burgett</i> 22c. DATE SIGNED <i>Sept. 6, 1968</i>							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 111 Green St. Elkhorn, Md.			
WENDELL J. BURGETT							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Sept 3, 1968 Wesley Chapel		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) Rock Hall Baltimore	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR Garrison O. William Chesnutton		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

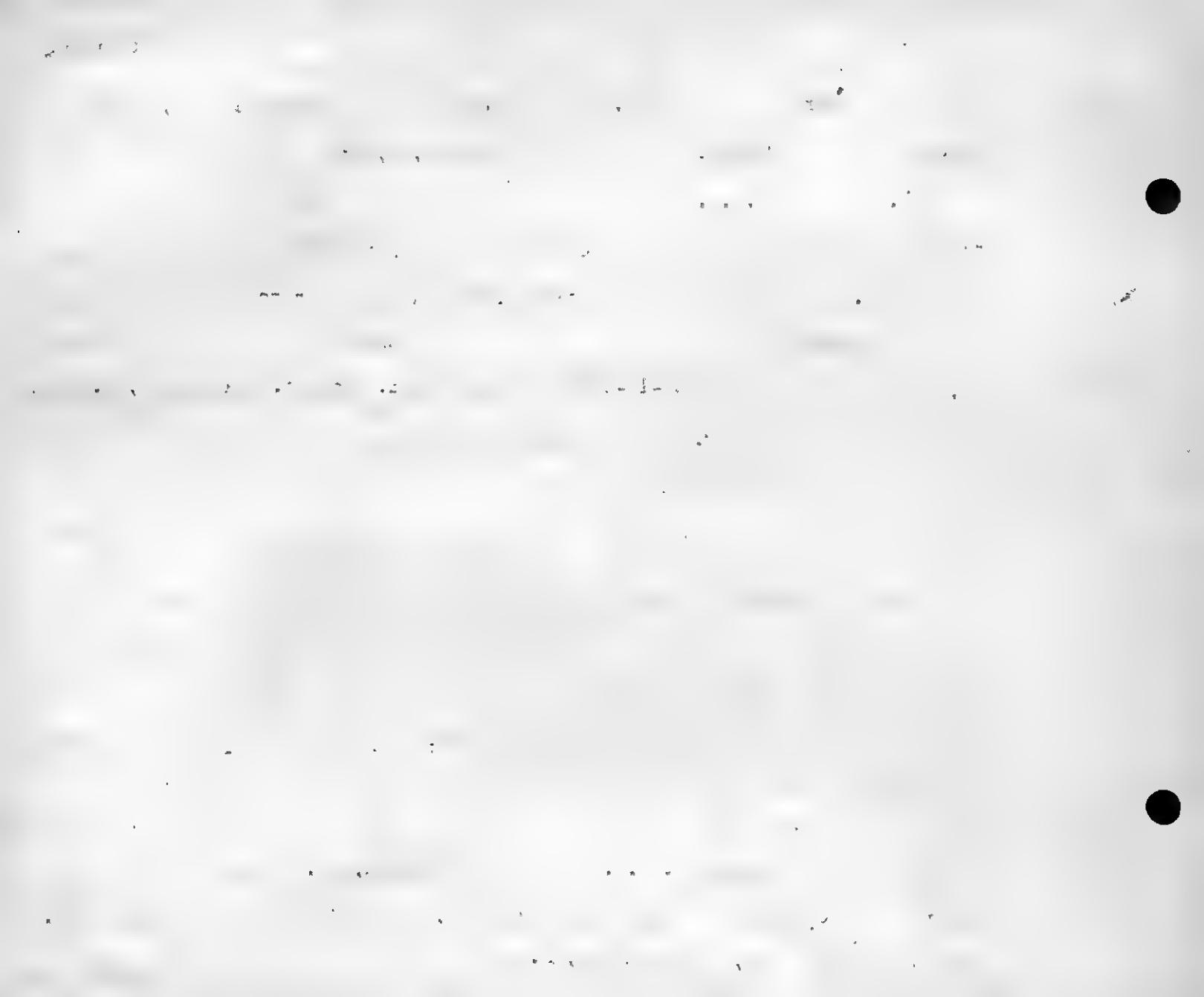
13040

13052

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Mary				First E.	Middle Gould	Last 	2a. DATE OF DEATH Month September	2b. HOUR Doy 2, 1968	
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH December, 25, 1883		6. AGE (in years last birthday) 84	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Millington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		lived, if institution: Residence before Kent		13c. CITY OR TOWN Millington	13d. INS DE CEM. L.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER -----			
14. FATHER'S NAME First Unknown		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Millie		Middle 	Last Watson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO 222-16-0498B		17. INFORMANT Willis Gould. Husband. Millington, Md. 21651		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF <u>15 years.</u> <u>10 years.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 18, 1968</u> , to <u>Sept 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug. 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Geza Koralewski -</u>		DEGREE ATTENDING PHYS.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 9.4.68 -		
22d. PHYSICIAN'S NAME (Type) Geza Koralewski, M.D.		22e. ADDRESS Millington, Md. 21651							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/7/68	23c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery		23d. LOCATION (City or Town) Millington		(County) Kent	(State) Md.	
24. FUNERAL DIRECTOR Edward Fellows & Son,		ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR DATE SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the funeral director's office. In any event, within 72 hours of death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

13041		13053									
1. DECEASED NAME (Type or print)		First Sarah	Middle C	Last Haver	2a. DATE OF DEATH 9/5/68	Day	Year	2b. HOUR 8:50P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-1-97		6. AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) Penns.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Kent County					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY 6666X					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER -----			
14. FATHER'S NAME Albert		First Middle Borcky		Last Harker		15. MOTHER'S MAIDEN NAME Rosa		Middle Reppert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> unknown		16b. SOCIAL SECURITY NO 194-22-8552		17. INFORMANT Hosp. records		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial infarcto</u> (b) <u>H.C.V.D</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>H.C.V.D</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>OBESITY</u>											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-5-</u> , 19 <u>68</u> , to <u>9-5-</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9-5-</u> 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jorge Oteiza</u>		22c. DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS		22d. DATE SIGNED <u>9-5-68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Chestertown, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE 9/9/68		23c. NAME OF CEMETERY OR CREMATORIUM IMMACULATE HEART CEMETERY		23d. LOCATION (City or Town) LINWOOD, DEL. CO., PENNA.		(County)		(State)	
24. FUNERAL DIRECTOR <u>J.Wells Wells</u>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE SEP 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13042

13054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Samuel	Middle David	Last Hurlock	2a. DATE OF DEATH 9 Month 5 Day 1968 Year	2b. HOUR 5:50P.M.	
3. SEX M	4. RACE W	S. DATE OF BIRTH 6/8/1904	6. AGE (in years last birthday) 64	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent County			
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent-Queen Anne's Railway Postal Service	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Post Off.	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Q.A. Co.	13c. CITY OR TOWN Crumpton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER -----		
14. FATHER'S NAME Samuel	First S.	Middle Hurlock	15. MOTHER'S MAIDEN NAME Maude	Middle Hurlock	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown	16b. SOCIAL SECURITY NO. _____	17. INFORMANT Hosp. records	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GANGRENE LEFT HEEL</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>SEVERAL YEARS</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>A.S.C.V.D.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>8-14-</u> , 19 <u>68</u> , to <u>9-5</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>9-5-</u> 19 <u>68</u> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <u>Jorge Oteiza</u>		DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>9-5-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>H.K.Y.</u> Jorge Oteiza, M.D.		22e. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/8/68</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Crumpton Cemetery</u>	23d. LOCATION (City or Town) <u>Crumpton</u>	(County) <u>Q.A.</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR Edward Fellows & Son,		ADDRESS Millington, Md.	25a. REC'D BY REGISTRAR DATE <u>SEP 10 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13043

13055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First George	Middle Beacher	Last Jones Sr.	2a. DATE OF DEATH 9-8-68 Month	Day	Year	2b. HOUR 5:45P.M.
3. SEX M	4. RACE W	5. DATE OF BIRTH 2-27-190			6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) K-WA Hospital			12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired.) Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admissn) STATE Md.	13b. COUNTY Kent Co	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER —			
14. FATHER'S NAME William	First Middle Jones	15. MOTHER'S MAIDEN NAME First XXXXXX	Middle Dena	Last Carrow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 215-26-5105 A	17. INFORMANT Hosp. Records	Address				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (b) H.C.V.D DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OBESITY							
19a. DATE OF OPERATION 14/11		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State
22a. MEDICAL CERTIFICATION 22b. I certify that (1) (this hospital) attended the deceased from 9-8-68 to 9-8-68, that (1) (we) last saw the deceased alive on 9-8-68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Oteiza MD		DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-9-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Chestertown - MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery		23d. LOCATION (City or Town) Millington	(County) Kent	(State) Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,		ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR DATE SEP 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Emma	Middle Clara	Last Lamb	2a. DATE OF DEATH Sept. 30, 1968	Month Sept.	Day 30	Year 1968	2b. HOUR 12 Noon
3. SEX Female	4. RACE White	5. DATE OF BIRTH October 1, 1888		6. AGE (In years last birthday) 79		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.,				
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY, J.M. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #1, Morgnec Road				
14. FATHER'S NAME First Edwin	Middle Boulter	15. MOTHER'S MAIDEN NAME Mamie		Middle Last Kelley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (if unknown) No	16b. SOCIAL SECURITY NO 219-34-3743	17. INFORMANT Hospital Records, Chestertown, Maryland		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic hypotension cardio vascular</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>HT</i>								
19a. DATE OF OPERATION 4/5		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1968, to Sept. 30, 1968, that (I) (we) last saw the deceased alive on Sept. 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A. C. Dick, M.D.</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9-30-68			
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.		22e. ADDRESS Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/3/68	23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION (City or Town) Chestertown		(County) Md.	(State)	
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>	ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

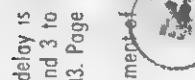


FOR STATE
HEALTH DEPT.

13045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13057



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR 19 9:30 P.M.		
John E. William Luike						9/25/68	19	9:30	P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years at birthday) YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS							
Male	White	May 2, 1895	73									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month Sep Year 1968				
Pennsylvania		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Kent		2d. HOUR 10:30 A.M.				
10. CITY OR TOWN OF DEATH Betterton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during past year, or home life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Fishing			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. CITY OR TOWN Kent			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Luike			16. SOCIAL SECURITY NO 213-14-1969			17. INFORMANT John Luike (son) Betterton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease			DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sixty years			
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)									
			DUE TO, OR AS A CONSEQUENCE OF									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNA. CASE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Robert W. Farr, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION REMOVAL, (Specify) BURIAL											23c. NAME OF CEMETERY OR CREMATORIUM STILL POND CEMTY.	
23b. DATE 9-28-68			23d. LOCATION (City or Town) (County) (State) STILL POND KENT MD									
24. FUNERAL DIRECTOR VICTOR N. KENNEDY STILL POND, MD.			ADDRESS			25a. REC'D BY REGISTRAR DATE SEP 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

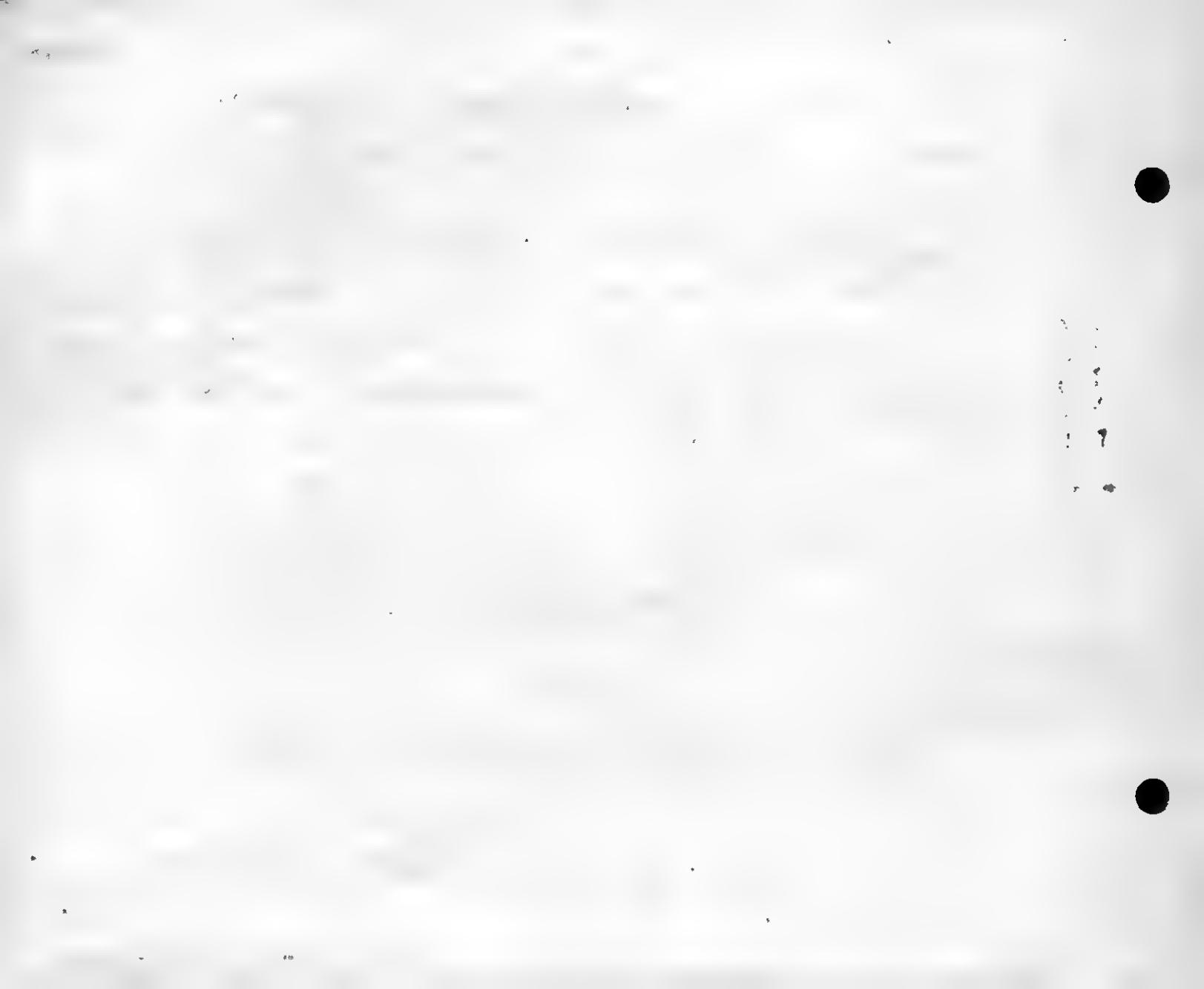
13046

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13058

1. DECEASED NAME (Type or print)	First Anna	Middle Cecelia	Last Massey	2d. DATE OF DEATH Month September Day 17 , Year 1968	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 3:45 P.M.
3. SEX Female	4 RACE White	S. DATE OF BIRTH June 29, 1901	6. AGE (In years last birthday) 67 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent Co.,		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Queen Anne	13c. CITY OR TOWN Church Hill	13d. INSIDE CITY L.M. 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Thomas	Middle Anthony	Last Mench	15. MOTHER'S MAIDEN NAME First Margaret	Middle Catherine	Last Uhlman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 218-10-4549	17. INFORMANT Hospital Records	Address Chestertown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) of Stomach DUE TO, OR AS A CONSEQUENCE OF last. (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 9/9/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric carcinoma	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from August 29, 1968 , to Sept. 17, 1968 , that (I) (we) last saw the deceased alive on September 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 	DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	ATTENDING PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 9/17/68		
22d. PHYSICIAN'S NAME (Type) A. T. Keefe, M. D.	22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 20	23c. NAME OF CEMETERY OR CREMATORIAL Church Hill	23d. LOCATION (City or Town) Church Hill, County Q.H. Md. State Q.H. Md.		
24. FUNERAL DIRECTOR Edgar L. Lane	ADDRESS Church Hill, Md.	25a. REC'D BY REGISTRAR DATE SEP 23 1968	25b. REGISTRAR'S SIGNATURE 		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13047

13059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retumed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Frederick William</i>	Middle <i>Norris</i>	Last	2a. DATE OF DEATH Month 9	Day 30	Year 68	2b. HOUR 4:10 P.M.
3. SEX <i>M</i>	4 RACE <i>W</i>	S. DATE OF BIRTH <i>3-6-91</i>	6. AGE (In years last birthday) 77 YRS				
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Kent County</i>				
10. CITY OR TOWN OF DEATH <i>Chestertown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kent Queen Anne Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Farmer Farming</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>	13b. COUNTY <i>Queen Anne Church Hill</i>	13c. CITY OR TOWN <i>Queen Anne Church Hill</i>	13d. INSIDE CITY LIMITS? <i>YES</i>	13e. STREET AND NUMBER <i>- - -</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Retired Farmer Farming</i>		
14. FATHER'S NAME First <i>Henry</i>	Middle <i>Norris</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Emma</i>	Middle <i>Brehm</i>	Last <i>Brehm</i>	Address <i>Chestertown, Md</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <i>No</i>							
16b. SOCIAL SECURITY NO. <i>216-12-3761</i>							
17. INFORMANT <i>Hospital Records</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acmeia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Bladde</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 yrs</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>1-19</i>							
19a. DATE OF OPERATION <i>—</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <i>—</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>—</i>	21f. LOCATION Street or R.F.D. No. <i>—</i>	City or Town <i>—</i>	County <i>—</i>	State <i>—</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>9-23-1968</i> to <i>9-30-1968</i> , that (I) (we) last saw the deceased alive on <i>9-30-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur T. Keele MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9-30-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Arthur T. Keele MD</i>	22e. ADDRESS <i>Chestertown Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-4-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Oak Lawn Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore</i> (County) (State) <i>Md.</i>				
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home 2401 Belair Road 21236</i>	ADDRESS <i>—</i>	25a. REC'D BY REGISTRAR <i>OCT 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13060

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM
Dr. GUSTAV Adolph PapperMAN					Sept. 15 1968	12 45 AM
3. SEX MALE		4. RACE WHITE	5. DATE OF BIRTH Age 85 yrs 10-22-1882 825 yrs		6. AGE (In years last birthday) F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH KENT CO.
10. CITY OR TOWN OF DEATH CHESTER TOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT and Queen Anne's M.S.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MINISTER		12b. KIND OF BUSINESS OR INDUSTRY Md
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13c. CITY OR TOWN KENT Co. Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
14. FATHER'S NAME First Ernest		Middle GXXXXXX	Last Adolph PapperMAN	15. MOTHER'S MAIDEN NAME First EMMA		Middle Pfeiffer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SEC. I.D. NO. 1918 217 36 1706		17. INFORMANT Hospital Records		Address Chestertown, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109		DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 das
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 9-15 1968 , to 9-15 1968 , that (I) (we) last saw the deceased alive on 9-15 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Harry P Ross MD		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-15-68	
22d. PHYSICIAN'S NAME (Type) HARRY P Ross		22e. ADDRESS Chestertown, Md 21620				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/18/68	23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery		23d. LOCATION (City or Town) Wilmington, Delaware	(County) (State)
24. FUNERAL DIRECTOR Wells		ADDRESS Chestertown, Md	25a. REC'D BY REGISTRAR DATE SEP 18 1988		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13061

13040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First ROLAND	Middle GEORGE	Last PORTER	2a. DATE OF DEATH Month 9	Doy 8	Year 1968	2b. HOUR 12 PM		
3. SEX Male	4. RACE White	S. DATE OF BIRTH 7-9-1887	6. AGE (In years last birthday) 81	IF UNDER 1 YEAR MONTHS DAYS					
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent	IF UNDER 24 HRS. HOURS MIN.					
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) truck Driver	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 230 Cross St.					
14. FATHER'S NAME First Henry	Middle ? Porter	15. MOTHER'S MADDEN NAME First Sarah	Middle ?	Last Mitchell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO 214 01 5753	17. INFORMANT Hospital Records	Address Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW WEEKS				
185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF CA OF PROSTATE (c) _____					2 YEARS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 8-18 , 19 68 , to 9-8 , 19 68 , that (I) (we) last saw the deceased alive on 9-7-1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 9-8-68	
22b. SIGNATURE Jorge A. Oteiza		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS CHESTER TOWN - MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/10/68		23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		23d. LOCATION (City or Town) Chestertown, Md.		(County) (State)	
24. FUNERAL DIRECTOR Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
				DATE SEP 11 1968					

4

1.



13050

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13062

Item#1, FilmGL05 10/7/68 km

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR M
Elizabeth Jones D.				Ramsey	9	28	68	2.15 M
3 SEX Female		4. RACE White		S. DATE OF BIRTH January 31-16-1896	6 AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS	
7a BIRTHPLACE (State or foreign country) Delaware		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Queen Anne Kent Kent		IF UNDER 24 HRS. MONTHS	
10 CITY OR TOWN OF DEATH Chestertown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Queen Anne's		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Queen Anne's		13c. CITY OR TOWN Chestertown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14 FATHER'S NAME John A. Danly		15 MOTHER'S MAIDEN NAME Mary					Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 221-07-3105		17 INFORMANT Kent & Queen Anne's Hospital, Chestertown, Md.			Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMATOSIS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS						
15.98 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF LARGE BOWEL (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 15.38								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 6-30, 1968, to 9-28, 1968, that (I) (we) last saw the deceased alive on 9-27-1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Jorge Oteiza</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED 9-30-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Chestertown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery		23d. LOCATED ON (City or Town) Crumpton, Md.		
24. FUNERAL DIRECTOR Willis Wells, Chestertown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

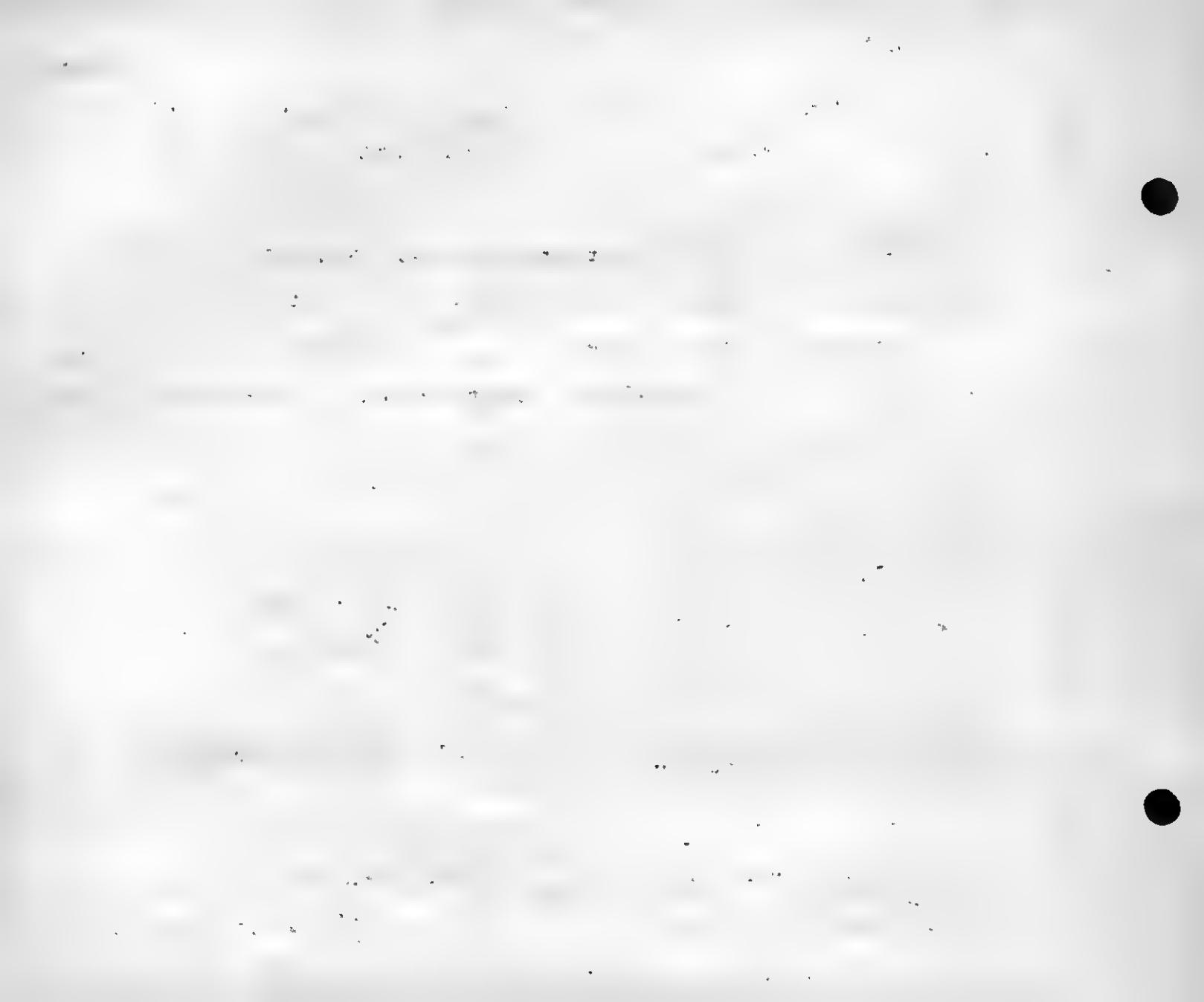
CERTIFICATE OF DEATH

13051

13063

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Both pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Clara	Middle Busey	Last Rasin	2a. DATE OF DEATH Month September	Day 2, 1968	2b. HOUR Year 5:05	
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 11, 1893		6. AGE (in years last birthday) 75		IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN A
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co.,			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #1		
14. FATHER'S NAME Harrison	First Earl	Middle Cooper	15. MOTHER'S MAIDEN NAME Elizabeth			Middle Ivens	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-20-5306	17. INFORMANT Hospital Records			Address Chestertown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 5749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterosclerosis C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) P. O. Arterosclerosis							
19a. DATE OF OPERATION 8.30.68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gall-Stones	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from August 19, 1968 , to September 2, 1968 , that (I) (we) last saw the deceased alive on September 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 	DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9.3.68		
22d. PHYSICIAN'S NAME (Type) A. T. Keefe, M. D.	22e. ADDRESS Chestertown, Maryland						
23a. BURIA, CREMATION, REMOVAL (Specify) Burial SEPT. 4, 1968	23b. DATE SEPT. 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL CHESTER CEMETARY	23d. LOCATION (City or Town) CHESTERTOWN KENT MD	(County) KENT	(State) MD		
24. FUNERAL DIRECTOR 	ADDRESS Marvin V. Williams, Chestertown Md	25a. REC'D BY REGISTRAR SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A154 30M REV 4/68							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13052

13064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Irene</i>	Middle <i>Mabel</i>	Last <i>Ward</i>	2a. DATE OF DEATH Month <i>9</i>	Day <i>9</i>	Year <i>68</i>	2b. HOUR <i>7:30 P.M.</i>			
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2-14-1897</i>		6. AGE (In years lost birthday) <i>71</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 12 HRS. HOURS <i>0</i>	MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Kent County</i>							
10. CITY OR TOWN OF DEATH <i>Chestertown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kent Queen Anne Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Houswife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Chestertown</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Tolchester Estates</i>						
14. FATHER'S NAME First <i>Pearl</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Greenwood</i>	Middle <i>Sophia</i>	Last <i>ANN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>105-01-4583</i>		17. INFORMANT <i>Hospital Records</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA TO SIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>C. A. LUNG</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>										
19a. MEDICAL CERTIFICATION <i>163 X</i>		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20d. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20e. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>7-23-</i> , 19 <i>68</i> , to <i>9-9-</i> , 19 <i>68</i> that <input type="checkbox"/> (we) last saw the deceased alive on <i>9-9-</i> 19 <i>68</i> and that in <input type="checkbox"/> (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (<i>did</i>) (<i>did not</i>) view the body after death.										
22b. SIGNATURE <i>Dre. Oteiza MD</i>		DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9-9-68</i>							
22d. PHYSICIAN'S NAME (Type) <i>Sorge Oteiza, M.D.</i>		22e. ADDRESS <i>Chestertown, Maryland</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>SEPT. 12</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>RIVERVIEW</i>			23d. LOCATION (City or Town) <i>BALDWINSVILLE</i>			(County) <i>N.Y.</i>	(State)
24. FUNERAL DIRECTOR <i>Edgar L. Lane - CHURCH HILL MD</i>		ADDRESS <i></i>			25a. REC'D BY REGISTRAR <i>SEP 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

2000 01 992

CERTIFICATE OF DEATH

13065

1. DECEASED-NAME (Type or print)			First MARION		Middle	Lost WEEKS	2a. DATE OF DEATH Sept. 26, 1968	2b. HOUR M
3. SEX female	4. RACE white	S. DATE OF BIRTH July 18, 1890	5. AGE (In years last birthday) 70 yrs.	6. IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co. Md.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 107 Water St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Librarian & Housewife		12b. KIND OF BUSINESS OR INDUSTRY Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Kent	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 107 Water St.				
14. FATHER'S NAME First Middle Last William F. Weeks			15. MOTHER'S MAIDEN NAME First Middle Last Mary Alice Denton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. None known	17. INFORMANT Hospital Records Chestertown, Md.			Address Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>			DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic cardiovascular disease</u> Years					
DUE TO, OR AS A CONSEQUENCE OF <u>(b) Arteriosclerotic cardiovascular disease</u>								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-15</u> , 19 <u>68</u> , to <u>9-26</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9-26-68</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A. C. Dick</u> M.D.		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/26/68		
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.		22e. ADDRESS Chestertown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/28/68	23c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery	23d. LOCATION (City or Town) near Chestertown, Md.		(County) (State)		
24. FUNERAL DIRECTOR F. Willis Wells		ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DA SEP 30 1968		25b. REGISTRAR'S SIGNATURE j Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send **M** and **2** to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

